is enrolled in the M+C plan, under the eligibility requirements at § 422.50(a)(3)(ii) or (a)(4), if the organization establishes, on the basis of a written statement from the individual or other evidence acceptable to CMS, that the individual has permanently moved from the residence in which she or he resided at the time of enrollment in the M+C plan, to an area outside the M+C plan service area (unless continuation of enrollment is elected under § 422.54). If the individual has not permanently moved from the residence in which she or he resided at the time of enrollment in the M+C plan, but has left the residence for over 6 months, the M+C organization must disenroll the individual.

(iii) *Notice of disenrollment.* The M+C organization must give the individual a written notice of the disenrollment that meets the requirements set forth in paragraph (c) of this section.

(5) *Loss of entitlement to Part A or Part B benefits.* If an individual is no longer entitled to Part A or Part B benefits, CMS notifies the M+C organization that the disenrollment is effective the first day of the calendar month following the last month of entitlement to Part A or Part B benefits.

(6) *Death of the individual.* If the individual dies, disenrollment is effective the first day of the calendar month following the month of death.

(7) *Plan termination or area reduction.* (i) When an M+C organization has its contract for an M+C plan terminated, terminates an M+C plan, or discontinues offering the plan in any portion of the area where the plan had previously been available, the M+C organization must give each affected M+C plan enrollee a written notice of the effective date of the plan termination or area reduction and a description of alternatives for obtaining benefits under the M+C program.

(ii) The notice must be sent before the effective date of the plan termination or area reduction, and in the timeframes specified in § 422.506(a)(2).

(e) *Consequences of disenrollment*—(1) *Disenrollment for non-payment of premiums, disruptive behavior, fraud or abuse, loss of Part A or Part B.* An individual who is disenrolled under paragraph (b)(1)(i), (b)(1)(ii), (b)(1)(iii), or paragraph (b)(2)(ii) of this section is deemed to have elected original Medicare.

(2) *Disenrollment based on plan termination, area reduction, or individual moves out of area.* (i) An individual who is disenrolled under paragraph (b)(2)(i) or (b)(3) of this section has a special election period in which to make a new election as provided in § 422.62(b)(1) and (b)(2).

(ii) An individual who fails to make an election during the special election period is deemed to have elected original Medicare.

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998, as amended at 65 FR 40318, June 29, 2000]

§ 422.80 Approval of marketing materials and election forms.

(a) *CMS review of marketing materials.* An M+C organization may not distribute any marketing materials (as defined in paragraph (b)), or election forms, or make such materials or forms available to individuals eligible to elect an M+C plan, unless—

(1) At least 45 days before the date of distribution the M+C organization has submitted the material or form to CMS for review under the guidelines in paragraph (c); and

(2) CMS has not disapproved the distribution of the material or form.

(b) *Definition of marketing materials.* Marketing materials include any informational materials targeted to Medicare beneficiaries which:

(1) Promote the M+C organization, or any M+C plan offered by the M+C organization;

(2) Inform Medicare beneficiaries that they may enroll, or remain enrolled in, an M+C plan offered by the M+C organization;

(3) Explain the benefits of enrollment in an M+C plan, or rules that apply to enrollees;

(4) Explain how Medicare services are covered under an M+C plan, including conditions that apply to such coverage;

(5) Examples of marketing materials include, but are not limited to:

(i) General audience materials such as general circulation brochures, newspapers, magazines, television, radio, billboards, yellow pages, or the internet.

(ii) Marketing representative materials such as scripts or outlines for telemarketing or other presentations.

(iii) Presentation materials such as slides and charts.

(iv) Promotional materials such as brochures or leaflets, including materials for circulation by third parties (*e.g.*, physicians or other providers).

(v) Membership communication materials such as membership rules, subscriber agreements (evidence of coverage), member handbooks and wallet card instructions to enrollees.

(vi) Letters to members about contractual changes; changes in providers, premiums, benefits, plan procedures *etc.*

(vii) Membership or claims processing activities (*e.g.*, materials on rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or annual notification information).

(c) *Guidelines for CMS review.* In reviewing marketing material or election forms under paragraph (a) of this section, CMS determines that the marketing materials:

(1) Provide, in a format (and, where appropriate, print size), and using standard terminology that may be specified by CMS, the following information to Medicare beneficiaries interested in enrolling:

(i) Adequate written description of rules (including any limitations on the providers from whom services can be obtained), procedures, basic benefits and services, and fees and other charges.

(ii) Adequate written description of any supplemental benefits and services.

(iii) Adequate written explanation of the grievance and appeals process, including differences between the two, and when it is appropriate to use each.

(iv) Any other information necessary to enable beneficiaries to make an informed decision about enrollment.

(2) Notify the general public of its enrollment period (whether time-limited or continuous) in an appropriate manner, through appropriate media, throughout its service and continuation area.

(3) Include in the written materials notice that the M+C organization is authorized by law to refuse to renew its contract with CMS, that CMS also may refuse to renew the contract, and that termination or non-renewal may result in termination of the beneficiary's enrollment in the plan.

(4) Are not materially inaccurate or misleading or otherwise make material misrepresentations.

(5) For markets with a significant non-English speaking population, provide materials in the language of these individuals.

(d) *Deemed approval (one-stop shopping).* If CMS has not disapproved the distribution of marketing materials or forms submitted by an M+C organization with respect to an M+C plan in an area, CMS is deemed not to have disapproved the distribution in all other areas covered by the M+C plan and organization except with regard to any portion of the material or form that is specific to the particular area.

(e) *Standards for M+C organization marketing.* (1) In conducting marketing activities, M+C organizations may not:

(i) Provide for cash or other monetary rebates as an inducement for enrollment or otherwise. This does not prohibit explanation of any legitimate benefits the beneficiary might obtain as an enrollee of the M+C plan, such as eligibility to enroll in a supplemental benefit plan that covers deductibles and coinsurance, or preventive services.

(ii) Engage in any discriminatory activity such as, for example, attempts to recruit Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas.

(iii) Solicit door-to-door for Medicare beneficiaries.

(iv) Engage in activities that could mislead or confuse Medicare beneficiaries, or misrepresent the M+C organization. The M+C organization may not claim that it is recommended or endorsed by CMS or Medicare or that CMS or Medicare recommends that the beneficiary enroll in the M+C plan. It may, however, explain that the organization is approved for participation in Medicare.

(v) Distribute marketing materials for which, before expiration of the 45-

day period, the M+C organization receives from CMS written notice of disapproval because it is inaccurate or misleading, or misrepresents the M+C organization, its marketing representatives, or CMS.

(vi) Use providers or provider groups to distribute printed information comparing the benefits of different health plans unless the materials have the concurrence of all M+C organizations involved and have received prior approval by CMS. Physicians or providers may distribute health plan brochures (exclusive of application forms) at a health fair or in their offices. Physicians may discuss, in response to an individual patient's inquiry, the various benefits in different health plans.

(vii) Accept plan applications in provider offices or other places where health care is delivered.

(viii) Employ M+C plan names that suggest that a plan is not available to all Medicare beneficiaries. This prohibition shall not apply to M+C plan names in effect on July 31, 2000.

(2) In its marketing, the M+C organization must:

(i) Demonstrate to CMS's satisfaction that marketing resources are allocated to marketing to the disabled Medicare population as well as beneficiaries age 65 and over.

(ii) Establish and maintain a system for confirming that enrolled beneficiaries have in fact, enrolled in the M+C plan, and understand the rules applicable under the plan.

(f) *Employer group retiree marketing.* M+C organizations may develop marketing materials designed for members of an employer group who are eligible for employer-sponsored benefits through the M+C organization, and furnish these materials only to the group members. While the materials must be submitted for approval under paragraph (a) of this section, CMS will not review portions of these materials that relate to employer group benefits.

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998, as amended at 65 FR 40318, June 29, 2000]

Subpart C—Benefits and Beneficiary Protections

SOURCE: 63 FR 35077, June 26, 1998, unless otherwise noted.

§ 422.100 General requirements.

(a) *Basic rule.* Subject to the conditions and limitations set forth in this subpart, an M+C organization offering an M+C plan must provide enrollees in that plan with coverage of the basic benefits described in paragraph (c) of this section (and, to the extent applicable, the benefits described in § 422.102) by furnishing the benefits directly or through arrangements, or by paying for the benefits. CMS reviews these benefits subject to the requirements of § 422.100(g) and the requirements in subpart G of this part.

(b) *Services of noncontracting providers and suppliers.* (1) An M+C organization must make timely and reasonable payment to or on behalf of the plan enrollee for the following services obtained from a provider or supplier that does not contract with the M+C organization to provide services covered by the M+C plan:

(i) Ambulance services dispatched through 911 or its local equivalent as provided in § 422.113.

(ii) Emergency and urgently needed services as provided in § 422.113.

(iii) Maintenance and post-stabilization care services as provided in § 422.113.

(iv) Renal dialysis services provided while the enrollee was temporarily outside the plan's service area.

(v) Services for which coverage has been denied by the M+C organization and found (upon appeal under subpart M of this part) to be services the enrollee was entitled to have furnished, or paid for, by the M+C organization.

(2) An M+C plan (other than an M+C MSA plan) offered by an M+C organization satisfies paragraph (a) of this section with respect to benefits for services furnished by a noncontracting provider if that M+C plan provides payment in an amount the provider would have received under original Medicare (including balance billing permitted under Medicare Part A and Part B).